BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of New Rules I through XIII and the amendment of ARM 37.106.1946 pertaining to crisis stabilization facilities	)))))	NOTICE OF ADOPTION AND AMENDMENT

TO: All Concerned Persons

1. On May 8, 2008, the Department of Public Health and Human Services published MAR Notice No. 37-441 pertaining to the public hearing on the proposed adoption and amendment of the above-stated rules at page 905 of the 2008 Montana Administrative Register, issue number 9.

2. The department has adopted New Rule II (37.106.2026), Rule IV (37.106.2038), Rule VII (37.106.2032), Rule VIII (37.106.2033), Rule X (37.106.2042), Rule XI (37.106.2046), Rule XII (37.106.2047), and Rule XIII (37.106.2048) as proposed. The department has amended ARM 37.106.1946 as proposed.

3. The department has adopted the following rules as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

RULE I (37.106.2025) APPLICATION OF OTHER RULES (1) In addition to the requirements established in this subchapter, each mental health center providing a secured in-patient crisis stabilization program shall comply with all the requirements established in ARM 37.106.1945 and 37.106.1946 with the exclusion of ARM 37.106.1946(3)(j).

(2) remains as proposed.

AUTH: 50-5-103, MCA
IMP: 50-5-201, MCA

RULE III (37.106.2027) DEFINITIONS In addition to the definitions in 50-5-101, MCA, the following definitions apply to this subchapter:

(1) "Crisis plan" means an initial, brief, individualized plan that:

(a) lists client problems identified by the secured crisis stabilization facility's mental health crisis assessment;

(b) lists the individual's strengths and resources;

(c) addresses cultural considerations;

(d) identifies support network options; and

(e) identifies referral and transition activities that will occur at discharge.

~~(1)~~ (2) "In-patient crisis stabilization program" means 24-hour supervised treatment for adults with a mental illness for the purpose of reducing the severity of an individual's mental illness symptoms.

~~(2)~~ (3) "Secured crisis stabilization facility (SCSF)" means a secure in-patient facility operated by a licensed hospital, critical access hospital, or a licensed mental health center that provides evaluation, intervention, and referral for individuals experiencing a crisis due to serious mental illness or a serious mental illness with a co-occurring substance use disorder. The facility may only provide secured services to a client when a detention exists as defined in 53-21-129, MCA.

AUTH: 50-5-103, MCA
IMP: 50-5-201, MCA

RULE V (37.106.2039) DISCHARGE PROCEDURES (1) through (1)(d) remain as proposed.

(2) The facility must ensure in-patient care is available through a critical access hospital or hospital transfer agreement for clients in need of an acute level of medical treatment.

AUTH: 50-5-103, MCA
IMP: 50-5-201, 50-5-202, MCA

RULE VI (37.106.2031) CONSTRUCTION REQUIREMENTS (1) through (3)(d) remain as proposed.

(4) The SCSF will provide access to a nourishment station or kitchen as required in the 2001 Edition of the Guidelines for the Design and Construction of Hospitals and Health Care Facilities, Section 8.2.C9, For Serving Nourishments Between Meals. A copy of this publication can be obtained from the Department of Public Health and Human Services, Quality Assurance Division, Licensure Bureau, 2401 Colonial Drive, P.O. Box 202953, Helena MT 59620-2953.

(5) through (6) remain as proposed.

(7) Patient rooms will be at a ratio of ~~100~~ 80 square feet for single bedrooms. The room square footage does not include bathrooms, door swings, alcoves, or vestibules. No more than one patient shall reside in a single room in a secured unit.

AUTH: 50-5-103, MCA
IMP: 50-5-201, MCA

RULE IX (37.106.2034) SECLUSION AND RESTRAINT (1) A SCSF must be capable of providing restraint or seclusion and must ensure that the restraint or seclusion is performed in compliance with 42 CFR 482.13(f)(1) through ~~(6)~~ (7). The department adopts and incorporates by reference 42 CFR 482.13(f)(1) through ~~(6)~~ (7) (July 2, 1999), which contains standards for use of seclusion and restraint for behavioral management.

(2) through (5) remain as proposed.

(6) A physician or other authorized health care provider must authorize use of the restraint or seclusion within one hour of initiating the restraint or seclusion. Each original order and renewal order is limited to four hours.

(7) Each order of restraint or seclusion is limited in length of time to a total of 24 hours.

(8) remains as proposed.

AUTH: 50-5-103, MCA
IMP: 50-5-103, MCA

4. The department has thoroughly considered the comments received. The comments received and the department's response to each follow:

COMMENT #1: One comment received requested that the department articulate the significant clinical differences for patients stabilized in the hospital emergency room, in-patient unit, or at the Montana State Hospital from those patients who might be referred to a crisis stabilization facility. This would help illuminate the likely purpose and use for the facilities and provide guidance for admission policies adopted by the facility.

RESPONSE: All facilities mentioned could serve the same patient unless the patient is acutely ill or medically unstable. Individuals who are subject to placement in a secure crisis stabilization facility have been assessed by a mental health professional that has rendered a determination that the person is a danger to self or to other persons because of a mental disorder. A licensed mental health professional (LMHP) can place a 24-hour hold or until the next working day, on a patient in any of the settings mentioned. The LMHP hold determination can be made in the Emergency Department (ED) and either admit the patient or initiate a transfer to a Secured Crisis Stabilization Facility (SCSF) or to another mental health facility. Where the ED would not be able to hold the patient beyond 24 hours, a SCSF can hold the patient for stabilization until commitment proceedings are completed. A decision regarding the appropriate placement of the individual in a hospital emergency room, in-patient unit, or at the Montana State Hospital would be based upon the clinical needs of the individual and requirements for safety, as well as an assessment of the available resources in the community. The department cannot articulate clinical differences for placement through administrative rules, when the community-based professionals are mandated by 53-21-129, MCA, to render a determination based on a combination of clinical standards, personal safety, and local and regional resources.

COMMENT #2: The same commentor included a concern that hospital emergency rooms might be accused of violating the stabilization and transfer requirements of federal EMTALA standards if the hospital medical staff transfers a patient to a SCSF.

The commentor asks, that the department provide guidance on its interpretation of the approved clinical condition under which the hospital can safely transfer a patient to a SCSF.

RESPONSE: The patient could be transferred to a SCFS if they did not require acute medical services and were medically stable, but experiencing a mental health crisis as determined by a LMHP or a physician that has rendered a determination that the person is a danger to self or to other persons because of a mental disorder. A decision regarding the appropriate placement of the individual from a hospital emergency room to a SCSF must be based upon the clinical needs of the individual and requirements for safety, as well as the available resources in the community. The department cannot articulate clinical differences for placement through administrative rules, when the ED based professionals are mandated by 53-21-129, MCA to render the determination on each patient's individual needs assessment which should be based on a combination of clinical standards, best practice, personal safety, and the local and regional resources.

COMMENT #3: A commentor expressed that facilities had concerns about available workforce, and adequate access to psychiatric and middle level professional treatment, access to labs, medications, et cetera, as needed for medical case management. These services were not described in detail in the rules and commentor would like to see those covered in detail.

RESPONSE: These rules are the minimum standards required for the daily operation of a SCSF facility. These rules do not address workforce shortages, or lacking access to professional treatment. The availability of workforce to staff a facility and a patient's lack of access to psychiatric and mid-level professional treatment are relevant to this rule only to the extent of the SCSF staffing requirements found within these rules.

COMMENT #4: Are there any on-call requirements required of local providers to the facility and how would that be outlined? Are there any other parameters or requirements around that?

RESPONSE: There are no on-call requirements in Rule X (ARM 37.106.2042). The rules provide the minimum requirements to operate and staff a licensed SCSF. Each facility shall develop appropriate policy and procedures regarding the provision of minimum licensing requirements of staffing levels, to meet both the patient and facility needs. The department would encourage cooperative relationships between local providers. However, whatever the relation, it will be as each see fit and not mandated by rule.

COMMENT #5: Page 911 of the published Rule Notice is unclear to the commentor. Does the notice propose the application of ARM 37.106.1946, Mental Health Center: In-patient Crisis Stabilization Program, requirements to the development of a secured in-patient crisis facility? If so, commentor is concerned about admission criteria. The commentor agrees that the secured in-patient crisis facility needs to

develop admission criteria, however, the minimum requirements for that criteria need to be different from that required for a mental health center in-patient crisis stabilization program that is not secure.

RESPONSE: Yes, the rule proposes the application of an in-patient crisis stabilization program (ICSP) to the SCSF. The department agrees the secured in-patient crisis facility shall develop admission criteria. The department also agrees the minimum requirements for that criteria need to be different from that required for a mental health center ICSP that is a voluntary service and is not secure. The department will place an exemption in the rule to exclude ARM 37.106.1946(3)(j) "establish admission criteria" found in ARM 37.106.1946.

COMMENT #6: One commentor remarked about ARM 37.106.1946(4) regarding training on therapeutic de-escalation of crisis situations should be done on hire/orientation to the position and thereafter updated per program policy but no less than biannually.

RESPONSE: The rule is written in a broader context than what the commentor would like to see. This has been done for a reason. By having the broader more general language, the provider is able to determine the plan of training for therapeutic de-escalation based upon their particular program and staffing needs. Should the provider choose to implement this training on hire/orientation, the rule does not prohibit this. The commentor would also like to see the rule address that the training be updated biannually; again, the rule doesn't preclude this, but requires the update to occur at least annually. Should the provider choose to update this training more frequently, the provider may do so by developing, and implementing new policy and procedures.

COMMENT #7: Commentor offered that more than any other service offered by mental health centers, this facility/program has a higher liability risk and provides a service otherwise provided principally by the state hospital. Providing the same level of indemnification available to the state when they provide this level of care is worth consideration as well. Indemnification may require a change in statute which is beyond the scope of these rules but should be considered separately by DPHHS.

RESPONSE: The department agrees that this comment is beyond the scope of the proposed rules and is not currently planning to pursue indemnification legislation.

COMMENT #8: The commentor is also in the situation of requiring placement in a secure setting under the mental health emergency detention provisions of 53-21-129, MCA, as a public safety precaution measure for either the individual and rarely for others who may be threatened with harm. The commentor strongly encourages the adoption of the provisions contained in these proposed rules which would permit the creation of a secure/in-patient program and facility which is both staffed and licensed to provide short term evaluation/stabilization to an individual in a crisis situation. Currently, the alternative most available for this type of situation is placement at Montana State Hospital. The commentor firmly believes that having

the alternative of using a community-based facility, rather than the state hospital, will result in less costly, less disruptive, and better access to treatment for the individual.

RESPONSE: The department thanks the commentor for their words of support for the implementation of these rules.

COMMENT #9: A commentor had questions regarding the proposed rules and their connection to the 72-hour presumptive eligibility program as well as the role of telepsychiatry in a facility of this nature. Would this be a part of the development of the procedures and processes that connect with the Montana State Hospital and other in-patient psychiatric facilities and is there any infrastructure possibilities for the development of the telepsychiatry concept?

RESPONSE: The 72-hour presumptive eligibility program is only available to a patient for a voluntary crisis stabilization stay as per 53-21-132, MCA. A patient stay in a SCSF does not qualify for the 72-hour presumptive eligibility program as the patient is involuntarily detained prior to a commitment.

Nothing in the rule would preclude the use, as appropriate, of telepsychiatry or the development of intra-connections with other psychiatric in-patient facilities or the MSH. The department is unaware of any developed infrastructure or infrastructure developing possibilities.

COMMENT #10: Commentor doesn't think that it is really clear if this is just a 72-hour facility or just 72 hours that a person is on an emergency hold.

RESPONSE: The department thinks the answer can be either. In either case, the secured portion of the SCSF is limited to the statutory timelines for involuntary commitment which is found at 53-21-129, MCA, and is limited to approximately 72 hours. If the commitment process is not concluded the patient can leave, be referred to an outpatient program, or where provided, voluntarily enter the facility's unsecured in-patient crisis program for whatever length of time is appropriate.

New Rule I (ARM 37.106.2025) Application of Other Rules

COMMENT #11: The department should clarify under the rule that a program of service provided by a crisis intervention facility operated by a community mental health center is not the same as a crisis intervention program offered by a community mental health center. This clarification should delineate the clinical differences in the services offered under each model.

RESPONSE: A crisis intervention facility and a crisis intervention program offered by a mental health center are the same. The crisis program and services referenced by the commentor are licensed under the authority of Title 50, MCA, Health Care Facility Licensing, as an endorsement under a mental health center facility license. All licensed services for crisis stabilization are under the mental health center facility licensed by endorsement and follow a logical continuum in the following manner:

(1) crisis telephone services are a required core service for any mental health center;

(2) an in-patient crisis stabilization program is a voluntary in-patient crisis response facility;

(3) a 24-hour outpatient crisis stabilization is for short term intervention assessment and referral; and

(4) the proposed secured stabilization facility is only for persons involuntarily held for stabilization by a LMHP.

Each of these programs is considered to be a crisis intervention "program" under a licensed mental health center by endorsement.

COMMENT #12: The commentor notes that 53-21-139, MCA, Crisis intervention programs provides:

"(1) The department shall, subject to available appropriations, establish crisis intervention programs. The programs must be designed to provide 24-hour emergency admission and care of persons suffering from a mental disorder and requiring commitment in a temporary, safe environment in the community as an alternative to placement in jail.

...

(3) The department may provide crisis intervention programs as:

(a) a rehabilitative service under 53-6-101(4)(j); and

(b) a targeted case management service authorized in 53-6-101(4)(n)."

It appears that a crisis stabilization facility is intended to provide services described above. That is, 24-hour emergency admission, requiring commitment and an alternative to placement in jail. But, the rules provide services beyond the scope of programs listed later in the statute.

RESPONSE: The licensing rules for a Mental Health Center providing crisis services are authorized under Title 50, chapter 5, parts 1 and 2, MCA, not under Title 53, MCA. The department agrees there is similarity between the two statutes. However, these rules are not written to enable Title 53, MCA, but to provide minimum standards for a Secured Crisis Stabilization Facility licensed under Title 50, chapter 5, part 2, MCA, the health care facility statutes.

New Rule III (ARM 37.106.2027) Definitions

COMMENT #13: One commentor noted above, at Rule III(2) (ARM 37.106.2027(2)) the department proposes to define a SCSF to be nearly identical to the conditions raised in 53-21-139, MCA.

RESPONSE: The department agrees with the comment and refers to the answer provided in the response to Comment #12.

COMMENT #14: Under New Rule III(2) (ARM 37.106.2027), Commentor asks if their understanding of the definition is correct that it means:

(a) The facility may provide care to clients who agree to treatment on a voluntary basis. Discharge and/or transfer arrangements must be made within 72 hours.

(b) The facility may also provide secured treatment to those clients that are being detained in 53-21-129, MCA. If the length of stay for the detention as defined in 53-21-129, MCA, exceeds 72 hours the client will be transferred by the county to the state hospital or other agreeable acute in-patient hospital.

RESPONSE: The commentor is incorrect. A SCSF may only provide secured services to a client when a detention exists as defined in 53-21-129, MCA. Clients who agree to treatment on a voluntary basis may be admitted to an in-patient crisis stabilization program defined in ARM 37.106.1946.

COMMENT #15: One person offered the following additional language for New Rule III(2) (ARM 37.106.2027). The facility may also provide secured treatment to those clients that are being detained as defined in 53-21-129, MCA. If the length of stay for the detention as defined in 53-21-129, MCA, exceeds 72 hours the client will be transferred by the county to the state hospital or other agreeable acute in-patient hospital.

RESPONSE: Disposition of the client at the end of the detention is defined in New Rule V (ARM 37.106.2039), therefore the department declines to add additional language to New Rule III(2) (ARM 37.106.2027) because it is unnecessary and redundant.

New Rule IV (ARM 37.106.2038) Admissions Procedure

COMMENT #16: One comment recommends that the department include at least some minimum criteria for patient admission in order to clarify clinical patient needs and standards.

RESPONSE: The department agrees, but feels 53-21-129(2), MCA, adequately covers this comment as follows: "If the professional person agrees that the person detained is a danger to the person or to others because of a mental disorder and that an emergency situation exists, then the person may be detained and treated until the next regular business day...". The department cannot articulate clinical differences for placement through administrative rules, when the community-based professionals are mandated by 53-21-129, MCA to render a determination based on a combination of clinical standards, personal safety, and local and regional resources.

Additionally, each facility must develop and implement policy and procedures that govern their daily operation which would include admission and discharge criteria.

The policies and procedures would be unique to each facility to allow full consideration of all local, regional, or state resources.

New Rule V (ARM 37.106.2039) Discharge Procedures

COMMENT #17: One commentor remains concerned that the rule provides for "transfer to an appropriate level of acute in-patient treatment". The commentor suggests that the department require the patient needing additional stabilizing care in excess of the time or medical capacity provided by the facility to be transferred directly to the Montana State Hospital. Alternatively, the rules could require the facility to hold a transfer arrangement with hospitals that provide in-patient psychiatric care and the Montana State Hospital. SCSFs are not subject to federal EMTALA standards and can affect appropriate transfers directly to MSH, thereby avoiding costly services of the hospital emergency room.

RESPONSE: The department feels that the rule does what the commentor is requesting. SCSFs cannot provide acute in-patient treatment. Any patient transfer from a SCSF must be determined by individual patient need. If a patient is not medically stable and needs to be seen in a medical environment, a transfer to a hospital would be appropriate. Any patient who is committed will be transferred to the state hospital. If there is no commitment made the patient is discharged from the SCSF and is free to go. Without a medical need or commitment there would be no transfer affected. However, the patient may be referred to a mental health center nonsecured in-patient crisis program, outpatient services, the state hospital, or to a hospital that provides in-patient psychiatric care based on bed availability and other community resources.

New Rule VI (ARM 37.106.2031) Construction Requirements

COMMENT #18: A commentor suggested that as long as a nourishment station as defined or other kitchen facility is located within the building and able to provide ice as needed to clients within the SCSF that this is reasonable and there is no need to have a nourishment station specifically located within the secure unit itself.

RESPONSE: The department agrees, but would point out that patient access to ice is not the only service provided by a nourishment station. Nourishment stations shall meet the requirements found in the 2001 edition of the AIA "Guidelines for Design and Construction of Hospitals and Healthcare Facilities". The department will amend the proposed rule to reflect "access to nourishment station or kitchen...".

COMMENT #19: Two comments were received suggesting that 80 square feet per patient bedroom is a reasonable size. One commented this is the standard used in all our new construction for residential crisis stabilization facilities for the past 15 years throughout the 15 county region and we have not received any complaints nor encountered any problems with this.

RESPONSE: The department agrees and will amend New Rule VI(7) (ARM 37.106.2031) to allow 80 square feet per bedroom of free and unobstructed space not inclusive of door swings, wardrobes, alcoves, or other nonuseable square footage.

New Rule VII (ARM 37.106.2032) Patient Toilets and Bathing

COMMENT #20: SCSFs will typically have fewer than five beds. One commentor thought it may be reasonable to require two toilets and bathing units for facilities up to five beds merely to allow reasonable and timely access, and gender separation and privacy.

RESPONSE: The department feels one water closet toilet and one bathing space is adequate for five people. The 2001 edition of the AIA "Guidelines for Design and Construction of Hospitals and Healthcare Facilities" require one toilet per six residents and one bathing unit for every 12 residents. The department does not wish to needlessly add to the cost of developing a SCSF. New Rule VII (ARM 37.106.2032) contains the minimum standards. It is discretionary for a SCSF to have additional toilets and bathing spaces. The department will not amend the rule to increase the minimum standards.

New Rule IX (ARM 37.106.2034) Seclusion and Restraint

COMMENT #21: The department is incorporating by reference hospital conditions of participation that are nearly ten years out-of-date. The commentor recommends that the department incorporate the latest version of the federal standard, including Parts e and f. Part e provides the most current practice on application and use of seclusion and restraints, while Part f provides for staff training and demonstration of competency.

RESPONSE: The department agrees the hospital "Conditions of Participation" (COP) are ten years outdated. The department agrees with the comment and will amend ARM 37.106.401(1) - Minimum Requirements for a Hospital, to incorporate the latest federal standard including Parts e and f as the state licensing requirements for a hospital. This will be taken care of in another notice that the department is currently working on for publication in the near future.

COMMENT #22: CMS Interim Rule adopted in 1999 has been replaced by the Final Rule effective 1/8/07 with interpretive guidelines to be issued in 2008.

RESPONSE: The department understands the commentor's concern. However, mental health centers and the various possible endorsements to a mental health center license, including a SCSF as proposed by this rule, do not qualify as a CMS "certified facility". Therefore, there is no need to incorporate or refer to CMS rules or guidelines.

COMMENT #23: Restraint and seclusion capacity in these facilities would require immediate access to qualified medical professionals to meet regulatory procedures surrounding this process and the ability to "one-to-one" a patient who was restrained or secluded under these procedures. The risks and dangers surrounding these procedures could possibly preclude an agency from referring a patient to a facility. There needs to be a real sense of safety (in the rules) for a medical professional to refer a patient to a facility that has the capacity of restraint and seclusion.

RESPONSE: The department agrees restraint or seclusion capacity in a SCSF requires immediate access to qualified medical professionals to meet regulatory procedures surrounding any restraint or seclusion which may be required for stabilization or de-escalation. As to the comment regarding a "real sense of safety for a medical professional" to refer the minimum requirements for the operation of a SCSF are established by these rules and are available for scrutiny by anyone. A review of any SCSF's policy and procedure manual, staffing availability (and staffing patterns), review of any transfer agreements or Memorandums of Understanding, understanding local and regional resources and finally an evaluation of the process and the ability for a SCSF to "one-to-one" a patient who was restrained or secluded; should give any professional a sense of the mental health center or SCSF competencies.

COMMENT #24: One comment was received regarding time limits in Rule IX(7) (ARM 37.106.2034). Time limits apply when restraint or seclusion are used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff members, or both. Orders indicate the time limitations and the time limit is included in the plan of care. Each original order and renewal order is limited in the plan of care. Each original order and renewal order is limited to four hours for adults; two hours for ages nine through 17, and one hour under age nine. Original orders may only be renewed by a physician or licensed independent practioner (LIP) in accordance with these limits for up to a total of 24 hours. Each renewal order must be renewed as authorized by facility policy. However, after 24 hours, if the patient is still under restraint or seclusion, the patient must be seen and assessed by a physician or LIP before a new order is written.

RESPONSE: The department agrees and will clarify the language of the rule to indicate that original orders for restraint and seclusion are limited to four hours; however the orders can be renewed by a physician or LIP for time limits not to exceed 24 hours. The SCSF will not be serving persons under the age of 18, therefore the references to time limits for persons aged nine through 17 and less than nine years of age as indicated by the comment will not be reflected in this rule.

New Rule XII (ARM 37.106.2047) Client Discharge

COMMENT #25: One commentor offered the following language modification to New Rule XII (ARM 37.106.2047) for consideration.

(1)(b) a summary of the services provided by the SCSF including recommendations for aftercare services and referrals to other services, as well as any other care coordination activities.

(e) the staff of the facility will prepare a crisis plan with the client.

RESPONSE: The department agrees with the comment and has added the suggested language and the following definition of "crisis plan" to New Rule III (ARM 37.106.2027), the definition rule.

"Crisis plan" means an initial, brief, individualized plan that:

(a) lists client problems identified by the secured crisis stabilization facility's mental health crisis assessment;

(b) lists the individual's strengths and resources;

(c) addresses cultural considerations;

(d) identifies support network options; and

(e) identifies referral and transition activities that will occur at discharge.

New Rule XIII (ARM 37.106.2048) Emergency Procedures

COMMENT #26: One commentor remains concerned that the SCSF might provide limited stabilization care, but transfer difficult patients, or those whose detention time expires to the local hospital emergency departments. The department should require SCSF to hold transfer arrangements for medical emergencies with community hospitals, but hold transfers for mental health conditions with hospitals that provide mental health services. This requirement will reduce, if not eliminate, wasteful use of emergency rooms and provide more efficient and appropriate mental health care to meet patient needs.

RESPONSE: The department partially concurs with this comment. A patient's detention time expiring is not a basis for continued secured stabilization. If the patient is not committed by court order then there is no transfer necessary as the patient can just leave. However for medically unstable patients, New Rule V (ARM 37.106.2039) will include (2), which will state:

"The facility must ensure in-patient care is available through a critical access hospital or hospital transfer agreement for clients in need of an acute level of medical treatment."

COMMENT #27: There needs to be a further clarification that if a patient is in a crisis stabilization facility that has an emergency situation occur(s) that there are agreements with the local emergency department(s) to be able to make a transfer and that it is an organized process that is recognized and understood by both facilities. Commentor handles such things through written agreements. Clarity around that would create a comfort level for providers involved in the process.

RESPONSE: Please see Response #26. The department will not amend the rule to require written transfer agreements between providers except as indicated in the

response above. However, the department does encourage an open dialogue and the development of agreements between all various providers in a given community. If a patient is experiencing a medical emergency, the transfer to an ED would be the only appropriate option to the SCSF. If the patient is in a mental health crisis that is beyond the SCSF's capability, the patient can only be referred to the state hospital or other acute care mental health facility with an in-patient psychiatric service/unit and an open bed.

/s/ Lisa H. Swanson
Rule Reviewer

/s/ Joan Miles
Joan Miles, Director
Public Health and Human Services

Certified to the Secretary of State September 2, 2008